16-CV-61670

Notice of Filing

IN THE UNITED STATES DISTRICT COURT SOUTHERN DISTRICT OF FLORIDA

Olivia Israel Modira

Plaintiff

v.

ChildNet Inc.

Defendant

NOTICE OF FILING

I, Olivia Israel Modira, hereby give notice that I have provided ChildNet with the appropriate documents to prove my case was mistreated and wrongly alleged. Attached are Jayden Devoe's, my son's medical records that proved I was taking care of him. These documents show where the investigators statement contradicted the medical records and the facts of my case.

I have filed the following documents: Jayden's medical records from Georgia, his medical records from Florida and my statements that I presented to ChildNet/DCF/and BSO.

Date: 9/9/16

Signature: [redacted]

"Without Prejudice" under UCC 1-308/207

Attorney (or ProSe Petitioner)

Name: Olivia Israel Modira

Address: 300 village Dr apt D4

City/State/Zip: Jacksonville nc, 28546

Telephone: [redacted] 910-554-9987

To whom it may concern,

I have been reaching out to the following companies, Department of Children and Families, ChildNet, and BSO of Florida for several months now for the misconduct presented in my case and the removal of my son from my custody. I have emailed and spoken to Kim Welles, John Harper, and several representatives from ChildNet only to be stuck in an endless cycle of being referred to other people about my problem. It has also been the same case with DCF and BSO. I have provided documents showing facts and evidence that there were fowl play and misconduct in the investigation performed by BSO/DCF and ChildNet. My son's medical records contradict the end result of the investigation, which claimed he was medically neglected. His records show that he was being seen for what was alleged. And my son's primary care doctor was located in the state of Georgia where he was checked prior to my visit to Florida. I was only in the state of Florida for less than a month when he was removed from my custody. It was also documented in the report that my son was living in a state of imminent danger before he was taken from me. I have also provided documents proving that the visiting residence he was taken from was not my residence. His legal father and I lived separately and his biological father is in prison. That was another false statement in the report. All I have asked for was an apology and for those that have falsified claims against me to be held accountable for their actions. And also for the return of my son for the fact that I committed no crime and have not harmed him in anyway. This situation have been a strain to my family emotionally and financially. I personally feel that because of my disability and being a victim of a stroke at an early age, I was targeted, and taken advantage of by those that were involved.

Olivia Israel Modira

Maiden Name: Davis

Contact: (910)-554-9987

Jayden Devoe Case.

On 10/21/10 my son Jayden Devoe was removed from my custody because of allegations of him being medically neglected. The court document (A) states that the Florida case worker Rayne Gutierrez had to advise me to seek medical attention for my son's abscess on the chin, sickle cell trait disease and stitches on the chin. He was removed because of my lack of understanding of what was going on. Currently in my possession are my son's full medical records. Several months prior to 10/21/10, my mother and I took the initiative to take my son to the doctor to check if he had any form of sickle cell. His biological father had sickle cell trait, so we wanted to be sure. My son Jayden Devoe was seen on 7/26/10, prior to my visit to Florida. The doctor stated in his records (B), that there were no obvious sickle cell in his body. A month later on 8/6/10, my son was seen for a follow-up. Medical records (C) shows a statement from the doctor that says that he had symptoms that were consistent with sickle cell trait which my likely be alpha- thalassemia. He did not have sickle cell and did not require therapy. But the report that was presented said that he had sickle cell trait disease, which was false. Medical record (D) shows that on 10/21/10 he was seen because of an abscess on his neck. She did not tell me to seek medical attention, I called the paramedics and he was taken to the hospital. He was in the hospital for 6 days, admitted on 10/09/10 and discharged on 10/15/10, he was released on a regular diet and with activity as tolerated. Also, I had to follow up with his primary care doctor. My son was only home for 6 days when he was removed, I rescheduled his appointment. I rescheduled his appointment for the following Monday to get his stitches. His stitches were not becoming infected. I have also provided copies of his record to ChildNet Inc., DCF, and Broward Sheriffs Office.

Olivia Modira

Sign: "Without prejudice" under UCC 1-308/207

09/8/16

IN THE CIRCUIT COURT OF THE
17TH JUDICIAL CIRCUIT IN AND
FOR BROWARD COUNTY, FLORIDA

IN THE INTEREST OF:

DEVOE, JAYDEN
DOB: 05/13/09

Minor Child
_____/

CASE NO. : 2010-8479 CJ-DP – (A)

JUDGE: KENNETH GILLESPIE
GENERAL MAGISTRATE UGARTE
NEXT HEARING: 12/9/11 @ 11:00 AM
TYPE OF HEARING: **JR**

NOTICE OF FILING

COMES NOW, the State of Florida Department of Children and Families, by and through its undersigned counsel, and gives notice of filing the following attached documents:

Termination of Supervision Report

I HEREBY CERTIFY that a true and correct copy of the foregoing Notice of Filing to: **Guardian Ad Litem Program**, 524 S. Andrews Avenue, Suite 300, Fort Lauderdale, Florida 33301; **Nicole Eaman,** Child Advocate, ChildNet, 313 North State Road 7, Fort Lauderdale, Florida 33317; **Frank Joseph Heston, Esquire**, Attorney for mother, 3300 University Drive, Suite 311, Coral Springs, Fl. 33065; **OCCCRC**, Attorney for the father, c/o OCCCRC Box, Broward County Courthouse, 201 S.E. 6th Street, Fort Lauderdale, Florida 33301, this 9th day of December, 2011.

PAMELA JO BONDI
Attorney General

By: _____

ANNEKE JOHNSON, ESQ.
Assistant Attorney General
Office of the Attorney General
Children's Legal Services
110 S. E. 6th Street
Suite 1200
Fort Lauderdale, FL 33301
Telephone: (954) 712-4747
Florida Bar No. 0044396

IN THE CIRCUIT COURT OF THE SEVENTEENTH JUDICIAL CIRCUIT OF THE STATE OF FLORIDA, IN AND FOR BROWARD COUNTY, FLORIDA

IN THE INTEREST OF:

COURT CASE NUMBER: 2010-8479

Child's Name	DOB
1. Jayden Devoe	[redacted]
2.	
3.	
4.	
5.	

Minor Child(ren)

TERMINATION OF SUPERVISION REPORT

This report is submitted to the Court on this 8 day of December, 201, for the purpose of requesting termination of supervision by DCF and its designee, ChildNet, as to the above-named children.

This case initially came into care due to issues of: (check all that apply)

- ☐ Abuse
- ☐ Abandonment
- ☒ Neglect

Specifically:
On 10/21/10, the child Jayden was removed from his mother, Olivia Davis due to medical neglect. Specifically, the PI received several reports on the mother. Each time she advised mom to seek medical treatment for the child's medical conditions, absess on the chin, sickle cell trait disease and stitches on the chin that needed to be removed as they were becoming infected. There were also reported allegations of DV between mom and dad, Dwayne Devoe with the child present. CPI stated that Jayden was very dirty and had on a very soiled diaper and a T-shirt.

The current court ordered case plan has a goal of:

- ☐ Reunification to be maintained and strengthened
- ☒ Reunification/Permanent Guardianship
- ☐ Adoption
- ☐ Fit and willing relative
- ☐ Another planned permanent living arrangement

At this time, we are requesting that the case plan goal:

☐ Remain the same as the current case plan goal
☐ Be amended to a case plan goal of:

☐ Reunification to be maintained and strengthened
☒ Permanent guardianship
☐ Other _____

The reason for this request to terminate supervision is due to:

☐ Adoption of the child(ren)
☒ The goals of the case plan have been successfully achieved and services successfully completed such that supervision is no longer necessary to ensure that the children's safety, health, and well-being is assured.
☐ The child has reached the age of majority and/or the disability of non-age has been removed by the Court and the child is no longer under the court's jurisdiction
☐ Other:

The child(ren) are presently placed with the following caretaker(s):

Child's name:	Custodian's name:	
Jayden Devoe	Arnette Davis	
Relationship to child:	Date of placement with custodian:	Telephone number:
Maternal Great Aunt	610 NW 7th Ave # 93, Pompano Beach, Fl 33060	(954) 934-5442
Custodian's Address: Street:	City:	State: / Zip Code:

Child's name:	Custodian's name:	
Relationship to child:	Date of placement with custodian:	Telephone number: ( )
Custodian's Address: Street:	City:	State: / Zip Code:

Child's name:	Custodian's name:	
Relationship to child:	Date of placement with custodian:	Telephone number: ( )
Custodian's Address: Street:	City:	State: / Zip Code:

The custodian of the child(ren) has been provided a copy of the change of address information form and has been advised of their on-going responsibility to notify the court, through the Broward County Clerk's Office, of any change in residence of the child in writing as required by law.

The following is a brief summary of the actions in this case (i.e. family's accomplishments, barriers/challenges, and services beyond those specified in the last JRSSR):

Ms. Arnette Davis has provided the child with basic needs, of food, shelter and clothing. Ms. Davis has statble housing and legal source of income. Ms. Davis addressed all of the child's medical, physical emotional needs.

Visitation for child(ren) with the parent(s) shall be as follows:

☐ Not at issue, as the child (ren) is (are) placed in the custody of the parent(s).
☐ Not at issue, as the child(ren) has had a finalization of adoption and is placed with the legal parent(s).
☐ Not at issue as the child (ren) has reached the age of majority and/or had the disability of non-age removed by the court.
☒ With the non-custodial mother, Olivia Davis, supervised by the maternal great aunt, Arnette Davis or the maternal cousin, Sheila Davis.
☒ With the non-custodial father Dwayne Devoe: supervised by the maternal great aunt, Arnette Davis or the maternal cousin, Sheila Davis.

The basis for the recommendations for visitation is:
In addition to the terms of the visitation, as stated-above, we recommend that the following actions/services as a condition of placement to ensure the health, safety, and well-being of the child(ren):

We ask that the Court adopt these recommendations as findings of the Court and grant our request for termination of supervision as stated in this report.

Respectfully submitted:

Germa Aime		12/07/11
Child Advocate's Name *(Print)*	Child Advocate's Signature	Date
Dawn Libetta	D. Libetta	12/7/11
Supervisor's Name *(Print)*	Supervisor's Signature	Date

with another male while holding the minor child and dropped the minor child during the altercation. The mother also stated that on another occasion, the father came to her residence and physically assaulted her in the presence of the child.

The CPI and Law Enforcement performed a home visit at the mother's current residence and observed the minor child dirty with a soiled shirt, a soiled diaper, and the bottom of his feet were black with dirt. The mother has a history of unstable housing and moves frequently. The mother is disabled and receives social security benefits. During the home visit, several adults were observed smoking marijuana outside of the home. While those individuals were being questioned, the mother's roommate attempted to commit suicide in the mother's home by swallowing a bottle of antidepressants.

These activities and/or environments harmed the child as defined in Florida Statutes 39.01 (32) and/or caused the child's physical, mental or emotional health to be significantly impaired.

amended

COUNT II AS

The child is dependent within the meaning and intent of Chapter 39.01(15) Florida Statutes, in that the mother has placed the minor child at imminent risk of neglect as defined in Florida Statute 39.01 (44) and/or harm as defined in Florida Statute 39.01(32). The acts constituting the imminent risk of neglect and/or harm include the following:

The mother, OLIVIA DAVIS, has placed the child, JAYDEN DEVOE, at imminent risk of abuse, as defined in Florida Statute 39.01 (02), neglect as defined in Florida Statute 39.01 (44) and/or harm as defined in Florida Statute 39.01(32) in that the mother has permitted the child to live in an environment which poses an imminent risk of causing the child's physical, mental or emotional health to be in danger or be significantly impaired

Aflac
Cancer Center &
Blood Disorders Service

Children's
Healthcare of Atlanta

1405 Clifton Road NE
4th Floor
Atlanta, Georgia 30322
404-785-1200
404-785-6288 fax
www.choa.org/cancer

EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

08/06/2010

Ramon Marques, MD
6911 Tara Blvd
Jonesboro, GA 30236

Re: Patient: DEVOE, JAYDEN
MR#: 210-89-10
DOB: [redacted]
VISIT DATE: 08/06/2010

Dear Dr. Marques:

This is a followup letter regarding Jayden Devoe. As you know, he is a 14-month-old African American male who we had worked up for possible sickle cell disease. Our laboratory evaluation is as follows: Again, his white blood cell count was 9.6 with 19 segs, 62 lymphs, and 9 monos. Absolute neutrophil count was 1.83. Hemoglobin and hematocrit were 10.6 and 34.8, respectively. Red blood cell count was 5.7 with an MCV of 61 and platelet count of 467,000. He had a hemoglobin electrophoresis which showed hemoglobin S of 30.4%, hemoglobin A2 of 4.1, and a hemoglobin A1 of 64.1%. This is consistent with sickle cell trait and likely alpha-thalassemia. At this point he does not need any penicillin prophylaxis. He is not in any increased risk for sepsis, splenic sequestration, aplastic crisis, etc. He should not be at increased risk for pain crisis or any other sickle cell complications. His hemoglobin and hematocrit will always be on the lower end of normal given his alpha-thalassemia trait. He does not require any iron therapy at this point.

If you have any questions or concerns, please do not hesitate to call.

Sincerely,

Michael Briones, DO
Assistant Professor of Pediatrics
MAB/gw D 08/06/2010 T 08/07/2010 7:22 A Job #0013319305 Doc #250898

Aflac
Cancer Center &
Blood Disorders Service

Children's
Healthcare of Atlanta

1405 Clifton Road NE
4th Floor
Atlanta, Georgia 30322
404-785-1200
404-785-6288 fax
www.choa.org/cancer

EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Physicians Final File

07/26/2010

Ramon Marquez, MD
6911 Tara Boulevard
Jonesboro, GA 30236

Re: Patient: DEVOE, JAYDEN
MR#: 210-89-10
DOB: [redacted]
VISIT DATE:

Dear Dr. Marquez:

Thank you for referring us Jayden Devoe. As you know, Jayden is a 14-month-old African American male who was referred here for possible sickle cell anemia. I am unsure of the exact diagnosis. The patient was born in Florida, the newborn screen is not available to us, and the mother and grandmother do not know at this time. The history is the grandmother believes he had some sort of sickle cell disease but has not been treated for any other sickle cell complications at this time. He has not had any fevers, extremity pain, or swelling of the extremities since being born. Mother denies that she has sickle cell disease but had a stroke at the age of 6. The etiology of her stroke was unclear. Grandmother was also not sure of the etiology of the mother's CVA. He is not on any kind of medication and was never placed on any penicillin prophylaxis or folic acid in the past. After further questioning of the mother, I asked why they had not brought Jayden for further evaluation, they stated that they had moved from Florida, but the history is somewhat questionable. He has not had any sickle cell care performed.

Diet is regular for age.

He has no known drug allergies.

He is currently not on any medication.

Immunizations are up to date, by history, but there is no documentation.

On examination, his temperature was 36.5, heart rate 65, respirations 26, and blood pressure 102/47. Weight was 10.8 kg. Height 73 cm. He appeared well developed and well nourished and in no acute distress. He was nontoxic appearing. HEENT: His head was normocephalic and atraumatic. Extraocular movements were intact. Pupils were equal, round, and reactive to light. Sclerae were clear. There was no jaundice noted. Tympanic membranes: Normal landmarks observed. No erythema. No exudates noted. Mouth was pink and moist. Oropharynx was clear. Neck was supple with full range of motion. Easy work of breathing. Lungs were clear to auscultation bilaterally without wheezes, rales, or rhonchi. Heart with regular rate and rhythm. No murmurs. Abdomen was soft, nontender, and nondistended. No hepatosplenomegaly. No masses palpated. Extremities: No clubbing, cyanosis, or edema. The patient was moving all 4 extremities well. Neurologic exam was nonfocal. Skin was warm and dry. No rashes noted.

We obtained a CBC with differential, which revealed a white blood cell count of 9.64 with 19 segs, 62 lymphs, and 9 monos. Absolute neutrophil count was 1.83. Red blood

cell count was slightly elevated at 5.7. Hemoglobin and hematocrit were 10.6 and 34.8, respectively, which was normal. MCV was low at 61.2. RDW was 20. Reticulocyte count was 1. Review of the peripheral smear revealed normal segmented neutrophils, normal lymphocytes, and no blasts appreciated. Red blood cell morphology was significant for 1+ target cells. The rest of the cells looked microcytic and hypochromic in nature. There were no obvious sickle cells. Occasional ovalocytes. We sent off a hemoglobin electrophoresis, which is pending at this time. We did chemistries, which showed a total bilirubin of less than 0.1 and AST and ALT of 47 and 6, which were normal. Sodium 137, potassium 4.8, chloride 105, CO2 25, BUN and creatinine of 15 and 0.3, calcium 10, total protein 6.3, and albumin 4.1.

Our impression at this time is that Jayden Devoe is a 14-month-old male with a questionable history of sickle cell disease. We do not know the newborn screening at this time. The family history, given by both grandmother and mother, is not complete, and both are very poor historians. On review of the peripheral smear, he is not anemic, but he has significant microcytosis. We suspect that he may have a thalassemia trait, but either sickle or thalassemia may still be in the differential.

Our plan is to obtain a hemoglobin electrophoresis at this time and see him back in 2 weeks. We went ahead and prophylactically placed him on penicillin prophylaxis, as well as folic acid, until we get the results back.

If you have any questions or concerns, please do not hesitate to call us.

Sincerely,

Michael Briones, DO
Assistant Professor of Pediatrics

Patient Name: DEVOE, JAYDEN
Date of Birth: [redacted]

MRN: 2871641, 1491920, 2462201 XXXXX6466
FIN: 102399111

* Auth (Verified) *

Review of Systems

Head ☐ non-contributory fell 10/8 3pm no swelling, no bleeding
☑ injuries ☐ headache

Eyes ☑ non-contributory
☐ visual changes ☐ cross-eyes or tendency ☐ discharge ☐ redness ☐ puffiness ☐ injuries ☐ glasses

Ears ☑ non-contributory
☐ difficulty hearing ☐ pain ☐ discharge ☐ ear infections ☐ myringotomy ☐ ventilation tubes

Nose ☑ non-contributory
☐ difficulty in breathing through nose ☐ bleeding through nose

Mouth and Throat ☐ none ☑ swelling of jaw
☐ sore throat or tongue ☐ difficulty swallowing ☐ dental defects ☐ hoarseness

Neck ☑ non-contributory
☐ swollen glands ☐ masses ☐ stiffness ☐ symmetry

Breasts ☑ non-contributory
☐ lumps ☐ pain ☐ symmetry ☐ nipple discharge

Lungs ☑ non-contributory
☐ shortness of breath ☐ able to keep up with peers ☐ cough with time of cough, character
☐ wheezing ☐ hemoptysis ☐ pain in chest

Heart ☐ non-contributory
☐ cyanosis ☐ edema ☑ heart murmurs ☐ heart "trouble" ☐ pain over heart

Gastrointestinal ☑ non-contributory
☐ appetite ☐ nausea ☐ vomiting with relation to feeding, amount, color, blood or bile stained, projectile
☐ bowel movements, with number and character ☐ abdominal pain ☐ abdominal distention ☐ jaundice

Genitourinary ☑ non-contributory
☐ dysuria ☐ hematuria ☐ frequency ☐ oliguria ☐ character of urinary stream ☐ enuresis
☐ urethral discharge ☐ vaginal discharge ☐ menstrual history
☐ sores ☐ pain ☐ intercourse ☐ venereal disease ☐ birth control, method

Extremities ☑ non-contributory
☐ weakness ☐ deformities ☐ difficulty in moving, walking ☐ joint pains ☐ joint swelling
☐ muscle pain or cramps

Neurologic ☑ non-contributory
☐ headaches ☐ fainting ☐ dizziness ☐ incoordination ☐ seizures ☐ numbness ☐ tremors

Skin ☑ non-contributory
☐ rashes ☐ hives ☐ itching ☐ color change ☐ hair and nail growth ☐ hair color and distribution
☐ easy bruising or bleeding

Psychiatric ☑ non-contributory
☐ usual mood ☐ nervousness ☐ tension ☐ drug use or abuse

Other:

N/A

(Cont'd)
Henry Lowe

ADDRESSOGRAPH

BROWARD HEALTH

PEDIATRIC HISTORY AND PHYSICAL EXAMINATION

P-10240 - 129700 - 2/09 *Page 2 of 4*

GMC

Broward Health Medical Center

Discharge Summary

DOCUMENT NAME:	DISCHARGE SUMMARY (SERVICE)	TRANSCRIBED BY:	Contributor_system,EMT (10/28/2010 12:15 EDT)
DOCUMENT TYPE:	Discharge Summary	PERFORMED BY:	SIEGEL DO,HAROLD J (10/28/2010 13:07 EDT)
RESULT STATUS:	Auth (Verified)	REVIEWED BY:	
SIGNED BY:	LIN MD,HENRY H (12/26/2010 00:50 EST); SIEGEL DO, HAROLD J (10/28/2010 23:43 EDT)	SERVICE DATE/TIME:	10/15/2010 00:00 EDT
AUTHENTICATED BY:	SIEGEL DO,HAROLD J (10/28/2010 23:43 EDT)		

DISCHARGE SUMMARY (SERVICE)

Name:	DEVOE, JAYDEN	Room:	
MR#:	1451920	Hos Svc:	
Acct.#:	000102399111	Adm. Date:	10/09/2010
Dict. Dr:	HAROLD SIEGEL, DO	Dis. Date:	10/15/2010
Dict. For:	HENRY H. LIN, MD		

Discharge Summary
Broward General Medical Center

ADMITTING DIAGNOSIS: Cellulitis and abscess of the face.

DISCHARGE DIAGNOSES:
1. Cellulitis and abscess of the neck.
2. Sickle cell trait.
3. Hypertension.

PROCEDURES: Incision and drainage of right neck abscess.

CHIEF COMPLAINT: The patient is a 17-month-old who woke up screaming, crying at 4 o'clock. The patient's primary physician, Lighthouse Point Pediatric Associates. Presents here, history of waking up at 4 o'clock this morning screaming and crying, noted to have a fever, put him in a cold bath, rocked him back to sleep. The patient is evaluated and found to have a right jaw abscess with pain, and patient is now admitted.

COURSE OF STAY: The patient was admitted to the pediatric floor, initiated on IV fluids, placed on ceftriaxone; and, at this time the patient was further evaluated by Dr. Dumornay noting patient with right neck abscess. On October 12, 2010 the patient underwent incision and drainage of right neck abscess. The patient was noted to tolerate the procedure well with no complications. Following the procedure, the patient was continued on appropriate antibiotic therapy. The patient remained under close observation. The patient was continued on clindamycin; and, by October 15, 2010 with the patient having tolerated the above therapy well the patient was much improved and medically stable for discharge.

PERTINENT LABORATORY DATA: Revealed WBC of 5.13, H and H 11.4 and 34.2. Blood culture negative. An ESR of 6. Fungal stain was negative.

DISPOSITION: The patient was initiated on aggressive medical support. The patient was noted to be tolerating the above therapy well, with vital signs remaining stable; and, now on October 15, 2010 the patient was much improved and medically stable for discharge home with mom with the following discharge instructions.

Discharge Summary

DISCHARGE MEDICATIONS: Clindamycin 75 mg per 5 mL, 10 mL t.i.d. for 4 days.

DISCHARGE DIET: Continue on a regular diet.

DISCHARGE ACTIVITY: Activity as tolerated.

DISCHARGE FOLLOW-UP: Follow up with primary physician in 2-3 days.

HENRY H. LIN, MD

HAROLD SIEGEL, DO

HS:emt7959
D:10/26/2010 15:53:20
T:10/28/2010 12:15:10
Job:550817/Voice Job:175661

SIEGEL DO, HAROLD J,DO

Electronically Signed Date/Time: 10/28/2010 11:43 PM

LIN MD, HENRY H, MD

Electronically Signed Date/Time: 12/26/2010 12:50 AM

History and Physical

Broward Health Medical Center

Consultation Report

CONSULT

Name:	DEVOE, JAYDEN	Room:	
MR#:	1451920	Hos Svc:	
Acct.#:	000102399111	Adm. Date:	10/09/2010
Dict. Dr:	WILSON DUMORNAY, MD	Consult:	10/11/2010

Consultation
Broward General Medical Center

Referring Physician:

REASON FOR CONSULTATION: Right submandibular abscess.

HISTORY OF THE PRESENT ILLNESS: This is a 1-year-old who presents with a three day history of right submandibular swelling with associated fever and chills. The patient had a CT of the neck on admission which revealed a collection of 2.5 fine needle fluid collection, indurated with erythema.

PAST MEDICAL HISTORY: None, sickle cell trait.

PAST SURGICAL HISTORY: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: None.

IMMUNIZATIONS: Up to date.

PHYSICAL EXAMINATION:

GENERAL: The patient is in no acute distress.

HEENT: External auditory canals without otorrhea. Tympanic membranes intact. Nares are without rhinorrhea or erythema. Oral cavity/oropharynx is without erythema, edema or exudates.

NECK: There is a firm white submandibular submental fullness measuring about 1.8 x 2.3 cm. It is tender to touch. No evidence of restriction of cervical range of motion.

CARDIOVASCULAR: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Soft, nontender, nondistended. Present bowel sounds.

EXTREMITIES: No cyanosis, clubbing or peripheral edema.

ASSESSMENT AND PLAN: Right submandibular abscess, the etiology of the abscess is unknown. I agree with intravenous clindamycin. We will do intravenous Decadron x3 doses. We will schedule the patient for incision and drainage of right submandibular abscess. Informed

Operative Note

COMPLICATIONS: None.

DISPOSITION: Stable.

INDICATION FOR PROCEDURE: This is a 17-month-old with a history of right neck abscess refractory to aggressive medical management. The risks and complications of the procedure were discussed with the patient's mother who understood and agreed to proceed with the surgery.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed supine on the table. After adequate IV sedation and general anesthesia with endotracheal intubation, the area was prepped and draped in the usual sterile fashion for this particular case. A 0.5 cm incision was made down to subcutaneous tissue. The skin was infiltrated with 0.25% Marcaine and with epinephrine 1:200,000. Approximately 1 mL was used in toto. Incision was carried down to the subcutaneous tissue. A hemostat was then used to open the abscess pocket and there was spontaneous decompression of gas and purulent drainage, approximately 1 mL in total. All loculations were broken and the wound was then copiously irrigated with saline and checked for hemostasis. Once we were satisfied, the skin edges were then reapproximated with 5-0 nylon in interrupted fashion. A rubber band drain was secured in place and pressure dressing was applied on the top. The patient returned to the anesthesiologist, extubated and transferred to the recovery room in stable condition. The patient tolerated the procedure well. There were no complications.

WILSON DUMORNAY, MD

WD:emt6500
D:10/12/2010 08:12:19
T:10/12/2010 10:18:01
Job:530189/Voice Job:163292

DUMORNAY MD, WILSON,MD

Electronically Signed Date/Time: 10/12/2010 12:18 pm

Surgery Record

DOCUMENT NAME:	BGOR PACU Phase I Record	TRANSCRIBED BY:	MAGALLON RN,FELMA
DOCUMENT TYPE:	Postoperative Record	PERFORMED BY:	(10/12/2010 10:13 EDT)
RESULT STATUS:	Auth (Verified)	REVIEWED BY:	
SIGNED BY:	MAGALLON RN,FELMA (10/12/2010 10:13 EDT)	SERVICE DATE/TIME:	10/12/2010 08:09 EDT
AUTHENTICATED BY:			

BGOR PACU Phase I Record